Reader: Please note that the following protocols (Open Enrollment, Eligibility Criteria, Intake, Financial Eligibility, Functional Eligibility, Enrollment, Non-Enrollment and Dis-enrollment) are currently in revision. The following features will be included in the new protocols:

ENROLLMENTS AND DISENROLLMENT SYSTEMS

Contents:

A. Outcome

SITE X's enrollment and disenrollment practices are both legal and fair.

The outcome is met when SITE X:

1. Follows written policies and procedures regarding enrollments and disenrollments which comply with applicable Federal and State laws and legislation;

2. Does not discriminate against individuals eligible to enroll on the basis of race, color or national origin and does not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin; and, does not discriminate in enrollment and disenrollment activities between individuals on the basis of medical history, current medical condition (except mental illness), required health care services, income, pay status, claims experience, or any other factor not applied equally to all.

B. Applicable Laws and Legislation

SITE X shall comply (to the extent compliance is required in light of the demonstration terms and conditions of October 16, 1998) with all applicable Federal and State laws and legislation relating to the outcome, including:

*42 C.F.R. 422.110 - Discrimination against beneficiaries prohibited.
*42 C.F.R. 438.56 - Disenrollment: Requirements and limitations.

*42 C.F.R 438.6 - Contract requirements.
*Wis. Stats. 146.81 - Health care records; definitions.
*42 C.F.R. 422.50 - Eligibility to elect an M+C plan.
*42 C.F.R. 422.54 - Continuation of enrollment.
*42 C.F.R. 422.56 - Limitations on enrollment in an M+C MSA plan.
*42 C.F.R. 422.57 - Limited enrollment under M+C RFB plans.
*42 C.F.R. 422.60 - Election process.
*42 C.F.R. 422.62 - Election of coverage under an M+C plan.
*42 C.F.R. 422.64 - Information about the M+C program.
*42 C.F.R. 422.66 - Coordination of enrollment and disenrollment through M+C organizations.
*42 C.F.R. 422.68 - Effective dates of coverage and change of coverage.
*42 C.F.R. 422.74 - Disenrollment by the M+C organization.
*42 C.F.R. 422.80 - Approval of marketing materials and election forms.
*42 C.F.R. 431, Subpart F - Safeguarding information on applicants and recipients.
*Division of Health Care Financing Policy Memo #3 November 5, 1999 entitled "Integration of Medicaid and Medicare Benefits in PACE and in Partnership Managed Care Programs."
*Wis. Administrative Code HFS 104.01(6) – Coverage While Out of State.

C. General Conditions Regarding Enrollment

1. SITE X shall provide voluntary and continuous open enrollment for anyone who:

    a. Is eligible for Medicaid or under provisions approved by CMS for the Partnership waiver to be determined prior to enrollment and annually thereafter;
    b. Is functionally eligible as determined via the Long-Term Care Functional Screen prior to enrollment and annually thereafter;
    c. Is living in the designated service area;
    d. Has not had one or more transplant surgeries considered experimental by the Wisconsin Medicaid Program; and,
    e. Is within the target group served by the contractor.

2. Enrollment of new members will take place in the following order:

    a. The date that all eligibility criteria were met;
    b. The date that the referral was received if the date of the referral was the same for two or more members who met the eligibility criteria on the same date.
    c. The time that the referral was received if the date of the referral was the same for two or more members who met the eligibility criteria on the same date.

3. SITE X has no limits on how many potential members eligible for Partnership may be enrolled in a given period of time. The Department, however, has established target member months of enrollment for the current Wisconsin biennial budget. The Department will inform SITE X of the target member enrollment months as they are established and any adjustments to the targets on a semi-annual basis. SITE X must monitor its utilization of member months and notify the Department immediately when SITE X's actual enrollment experience varies significantly (3% or more) from the target.

4. The Department will regard people who have been in nursing facilities with funding provided by Medicaid (no Medicare) for no less than 30 consecutive days as nursing home, long-term care recipients. SITE X will make information on relocations available to the Department upon request.

5. Non-Enrollment

   SITE X may request a non-enrollment for any of the following reasons:

   a. Protocol #1. The individual has a demonstrated history of physical aggression which places others and/or self at risk as demonstrated by clinical/medical records, family information, etc., AND, documented previous attempts at treatment or plan intervention have been unsuccessful, resulting in physical risk to the individual or others.
   b. Protocol #2. The potential member has a history of willful non-compliance with an essential treatment plan which has resulted in significant physical risk to the individual. This protocol is applicable if:
      i. The willful non-compliance and the physical risk have been actively occurring in the six (6) months prior to the non-enrollment request;
      ii. The willful non-compliance and the physical risk is evidenced by medical records; and,
      iii. The physical risk to the individual continues.
   c. Protocol #3. The potential member and/or potential member's family/guardian express the desire for the potential member to remain at home (or, if the potential member is currently in a nursing home or an alternative setting such as a CBRF, to return home) but the team, along with the potential member, the potential member's primary care physician and SITE X's medical director, cannot develop a care plan which complies with WPP practice guidelines and the standards of practice for medicine and nursing in Wisconsin.
   d. Protocol #4. The potential member has a less-than-six-month life expectancy.

e. Protocol #5. The potential member and/or potential member's guardian or durable power of attorney for health care refuse an essential component of the treatment plan.
f. Protocol #6. The potential member, at the time of referral, is living in substitute care (substitute care includes but is not limited to Nursing Home, Adult Family Home, or CBRF) with no desire to change residence or cannot with natural supports and the program return to their own or their family home.
g. Protocol #7. The potential member has a primary diagnosis which is excluded in the capitation rate. This includes, but is not limited to, people with mental retardation (a full scale IQ of 70 or less as ascertained by recent testing); people with major mental illnesses who are currently a risk to themselves or others as documented by the treating psychiatrist; and, people with traumatic head injuries where cognitive and behavioral symptoms are evident.
h. Protocol #8. The potential member's physician does not meet Partnership criteria or the potential member's physician refuses to participate in the Partnership model and the potential member refuses to change physician.

6. Non-Enrollment Procedures

a. The Department will review SITE X's request for non-enrollment and either approve or disapprove it in writing within fifteen (15) days; and,
b. If the Department disapproves the request for non-enrollment, SITE X shall contact the person and offer enrollment.
c. Notification to Applicant: If the Department upholds SITE X's denial, SITE X must send written notification to the applicant with the following information:
    i. A statement that the enrollment is denied;
    ii. A written notification to applicant explaining the reason for denial;
    iii. A statement advising the applicant about the rights of the applicant to appeal the denial; and, that the applicant may appeal to SITE X, the Department, and/or the Division of Hearings and Appeals.
d. SITE X shall not counsel or otherwise discourage enrollment of a potential enrollee with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code or who is HIV-Positive if that person is on antiretroviral drug treatment approved by the Federal Drug Administration.

D. Voluntary Disenrollment

SITE X shall not counsel or otherwise encourage voluntary disenrollment of an enrollee with a confirmed diagnosis of AIDS, as indicated by an ICD-9-CM diagnosis code or who is HIV-Positive if that person is on antiretroviral drug treatment approved by the Federal Drug Administration.

Members may voluntarily disenroll without cause at any time.

E. Involuntary Disenrollment

1. Involuntary Disenrollment from Partnership. SITE X may not request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except as specified in items a. through d. below). The Department has approved the following special "Protocols for Disenrollment" from Partnership:

    a. The member has a demonstrated history of ongoing, willful non-compliance with an essential treatment plan that has resulted in significant physical risk to the individual as demonstrated by clinical records, and that risk continues.
    b. The cognitively impaired member's informal support system fails to protect the member from abuse and/or neglect in the home setting, AND, there is significant risk to the person, AND, the family or guardian refuses an alternate living setting.
    c. The program no longer has a contract with the member's physician, AND, the member refuses to change physicians.
    d. The member has committed acts of physical or verbal abuse that pose a threat to SITE X staff, subcontractors or other members of SITE X. This includes but may not be limited to verbally threatening behavior or an exhibition of harassing behavior.

2. Department Approval for Involuntary Disenrollment.

    Involuntary disenrollment from Partnership requires the Department's approval. A proposed involuntary disenrollment shall be subject to timely review and prior authorization by the Department, pursuant to Subsection 3, Involuntary Disenrollment Procedure, below. SITE X can request involuntary disenrollment for any of the following reasons:

    a. Absence. When the member is out of the service area for more than thirty (30) consecutive days, unless SITE X agrees to a longer absence due to extenuating circumstances (see 42 CFR 460.164(a)(3)).

b. Protocol Provisions. When a member's case meets one of the protocols for disenrollment, pursuant to Section 1, Involuntary Disenrollment from Partnership, above.
c. Contract termination or loss of either HMO Licensure or exemption from HMO Licensure.

3. Involuntary Disenrollment Procedure.

a. Disenrollment Request. SITE X shall submit to the Department a written request to process all involuntary disenrollments. With each request, SITE X shall submit to the Department evidence attesting to the above situations.
b. Department's Approval. The Department will notify SITE X about its decision to approve or disapprove the involuntary disenrollment request within fifteen (15) days from the date the Department has received all information needed for a decision.
Upon Department approval of the disenrollment request, SITE X must, within three (3) business days, forward copies of a completed Disenrollment Request form to the County Economic Support Worker and to the Medicare enrollment agency (for dual eligibles).
c. Notification to the Member. When the Department approves SITE X's request, SITE X must send written notification to the member that includes:
    i. A statement that SITE X intends to disenroll the member;
    ii. The reason(s) for the intended disenrollment; and,
    iii. A statement about the member's right to challenge the decision by asking for reconsideration from the Department to disenroll and how to appeal such a decision. (See Partnership protocol on "Complaint and Appeals.")

4. The Department will make all involuntary disenrollment decisions based upon criteria and procedures set forth in this contract and will be effective as described in Addendum I.

5. Disenrollment Appeal. If the member files a written appeal of the disenrollment within ten (10) days of the decision to disenroll (see Article IX, L.), disenrollment shall be delayed until the appeal is resolved.

F. Loss of Waiver Eligibility

1. A member can lose Partnership waiver eligibility for the reasons stated below (a.-d.). The effective disenrollment dates for loss of waiver eligibility are as follows:

a. Loss of Financial Eligibility. If the member is determined to be financially ineligible, their enrollment will end concurrent with Medicaid eligibility as described in Addendum I.
b. Loss of Functional Eligibility. If the member is determined to be functionally ineligible, SITE X will notify the appropriate county Economic Support Worker within five days. Eligibility will cease as described in Addendum I.
c. Out of Area Residence. If the member moves permanently out of the catchment area, the date of disenrollment shall be the date when the move occurs. The Department will recoup capitation payment to reflect a mid-month disenrollment and will continue to recoup any whole capitation payments made for months subsequent to the month an out of area move occurs.
d. Death. If the member dies, the date of disenrollment shall be the date of death. The Department will recoup capitation payment to reflect a mid-month disenrollment and will continue to recoup any whole capitation payments made for months subsequent to the month a member dies.

2. Notification to the Member. When SITE X notifies the County and Medicare enrollment agencies of the loss of waiver eligibility, SITE X shall also send written notification to the member. This written notification shall include:

    a. A statement that the member is no longer eligible for the Partnership program;
    b. The reason(s) for the loss of waiver eligibility; and,
    c. The phone number of the County Economic Support Worker if Medicaid eligibility was established through the County or the Social Security Administration if the person has SSI.

G. Re-Enrollment and Transition Out of SITE X

1. All re-enrollments will be treated as new enrollments except that when a member re-enrolls within two months after losing waiver eligibility, that member's re-enrollment will not be treated as a new enrollment.

2. SITE X shall assist participants whose enrollment ceases for any reason in obtaining necessary transitional care through appropriate referrals, by making medical records available to the participants' new providers; and, (if applicable) by working with the Department to reinstate participants' benefits in the FFS system.

Enrollment and Disenrollment Systems

Open Enrollment

Policy Statement:
The Wisconsin Partnership Program must provide voluntary and continuous open enrollment up to the limit set under the Medicaid/Medicare contracts.

Procedure:

1. All Partnership members must meet the eligibility criteria in the Wisconsin Partnership Program Protocol.

2. Exceptions to eligibility and enrollment appear in the Non-Enrollment protocol.

3. The following enrollment activities are prohibited:

    a. Practices that are discriminatory

    b. Activities that could mislead consumers

    c. Offers of gifts, compensation, benefits, or rewards as inducements to enroll

References:
Dual Waiver Contract, Article VIII
Medicare CFR 417.422 - 417.430
Medicaid CFR 434.25

Cross Reference:
Eligibility Criteria
Financial Eligibility
Functional Eligibility
Enrollment
Non-Enrollment

Enrollment and Disenrollment Systems

Eligibility Criteria

Policy Statement:
All potential members are screened for eligibility based on the criteria outlined in this protocol. Exceptions to eligibility and enrollment appear in the Non-Enrollment protocol.

Procedure:

1. The potential member for the Elderly Model must:
   a. Be age 55 years or older,
   b. Reside in a county as specified in the Dual Waiver Contract,

2. The potential member for the model for People with Physical Disabilities must:
   a. Be between 18 and 64 years of age,
   b. Reside in a county as specified in the Dual Waiver Contract,
   c. Have a physical disability as their primary disabling condition.

3. All members and potential members must be certified as requiring nursing home level of care by the DHFS Bureau of Quality Assurance.

4. All members and potential members must be financially eligible for the program as described in the Financial Eligibility Protocol.

5. The Non-Enrollment Protocol will be applied to guide exceptions to enrollment of eligible individuals.

6. Persons who are enrolled in the following programs are not eligible:
   a. Medicare hospice (See Hospice Protocol)
   b. Kidney transplant in the last 12 months

References:
Dual Waiver Contract, Article I
Medicaid CFR 456.350-456.380
Medicaid CFR 435.217

Cross-Reference:
Non-Enrollment
ESRD
Hospice

Enrollment and Disenrollment Systems

Intake

Policy Statement:
The intake process for the Wisconsin Partnership Program will include the following elements:

1. Providing Partnership Program information to the potential member and identifying the member's primary care physician.

2. Assessing for financial eligibility as defined by the Financial Eligibility Protocol.

3. Assessing for functional eligibility as determined by the DHFS Bureau of Quality Assurance using the ARequest for Title XIX Level of Care Determination≅ form. See Functional Eligibility Protocol.

4. Obtaining member or guardian sign off on the initial plan of care.

5. Implementing the initial Personal Care Worker/Daily Living Assistant plan.

Procedure:

1. Staff from the Partnership organization meet with the potential member and/or with the potential member's significant others or legal guardians to explain:

4.

   a. The health benefits and services provided by the program

   b. Eligibility requirements

   c. Estate recovery, cost share and other financial aspects

2. Staff will provide and explain to the potential member the handbook and list of current providers.

3. Staff will obtain a release of information if the potential member chooses to continue the intake process.

4. Staff will process financial and functional eligibility.

Reference:
Medicaid CFR 435.217
Medicaid CFR 456.350-456.380

Dual Waiver Contract, Addendum VIII

Cross Reference:
Financial Eligibility
Functional Eligibility
PCW/DLA Plan

Enrollment and Disenrollment Systems

Financial Eligibility

Policy Statement:
It is the policy of the Wisconsin Partnership Program to apply financial eligibility and cost sharing rules consistently for all members and potential members. The member or potential member must be eligible under the financial rules of the Wisconsin State Medicaid plan or the Wisconsin Partnership Program Waiver.

Procedure:

1. Personal Asset Limitations
   a. Asset Limit: The potential member must meet the Medicaid asset limit. A home and furnishings are exempt assets, but may be subject to estate recovery.

   b. Divestment: If the potential member has divested assets in the past 3 years, eligibility will be deferred for the number of months equal to the dollar value of the assets transferred divided by the average monthly self-pay nursing facility rate in their county of residence, rounding fractions down.

   c. Spousal Impoverishment Protections: The potential member may delegate assets up to the Maximum Spousal Asset Allocation to his or her spouse. This may occur only once, at the beginning of their eligibility for Medicaid or Waiver services.

   d. Estate Recovery Provisions: None apply at this time under the dual waiver.

2. Income Status
   Members must be eligible under one of the following income related categories:
   a. Categorically eligible
   b. Eligible under a special income limit
   c. Medically needy

3. Cost Share and Patient Liability
   Members may be subject to cost sharing and/or patient liability.

Reference:
Dual Waiver Contract, Article I
Medicaid CFR 435.217

Cross-Reference:
Non-Enrollment
Home and Community-Based Waiver Technical Assistance Manual

Enrollment and Disenrollment Systems

Functional Eligibility

Policy Statement:
The member or potential member must meet functional eligibility as determined by the Department of Health and Family Services, Bureau of Quality Assurance (BQA) using the ARequest for Title XIX Level of Care Determination Form.≅

Procedure:

1. Functional Eligibility

    a. The Intake Registered Nurse in the Partnership organization will perform an in-person health assessment and review copies of medical records to determine functional eligibility and the need for daily living assistance.

    b. Based on the assessment and review of records, the Intake Registered Nurse completes the ARequest for Title XIX Level of Care Determination≅ form and prepares an initial plan of care for the potential member. The initial plan includes the potential member's diagnosis, medications, and recommendations for skilled nursing, therapies, personal care and medication management.

    c. The Registered Nurse meets with the BQA surveyor and obtains the final Level of Care Determination and surveyor signature.

2. Functional Eligibility Redeterminations

    a. Redeterminations for functional eligibility (level of care) are not required.

    b. If the Partnership organization feels that the member's care needs have increased significantly, the Partnership organization may request that BQA redetermine level of care.

Reference:
CFR 456.350-456.380

Cross Reference:
Marketing
Financial Eligibility

Enrollment and Disenrollment Systems

Enrollment

Policy Statement:
Once the prospective member has met functional and financial eligibility requirements and agreed to enroll, he/she must sign an enrollment agreement and an enrollment request.

Procedure:

1. A Partnership staff person meets with the prospective member and/or significant others to review the following documents and obtain signatures, (where applicable):

   a. Member Handbook

      The Member Handbook contains key information the member needs to be fully informed about the decision to enroll, including informed choice and voluntary enrollment requirements (lock-in). A copy of the Member Handbook must be provided to the prospective member prior to enrollment.

   b. List of current providers

   c. Enrollment Request Form

      The Medicare and Medicaid enrollment requests are to be signed by the member. The Partnership organization will forward the request to the Medicaid fiscal intermediary and the Medicare enrollment agency (via DHFS) for processing. See the attached Partnership Enrollment Request Form.

   d. Enrollment Agreement

      The enrollment agreement is between the contractor and the member, outlining services, benefits, procedures, rights, and responsibilities. Partnership intake staff give one copy to the member, retain the other in permanent records of the contractor. See the attached Enrollment Agreement.

2. Enrollment package

   Once the member signs the enrollment agreement, the staff person will provide the member with copies of the following within one week:

   a. A copy of the Enrollment Agreement.

b. Emergency instructions including phone numbers, to be posted in the member's home in case of emergency. Similar information will be provided on a wallet card which the participant will be asked to carry with their Medicaid and Medicare cards.

c. Sticker for member's Medicare card, if applicable.

3. Enrollment processing

a. The Partnership Registered Nurse will prepare Title XIX Level of Care forms and initial plan of care, and will meet with the State Bureau of Quality Assurance nurse surveyor. The Bureau of Quality Assurance will determine the appropriate level of care and sign the forms. A copy of the completed Title XIX Level of Care certification is placed in the member's file.

b. The Partnership intake staff will provide the county Medicaid eligibility agency with financial eligibility information. The county Medicaid eligibility organization will key needed information into the CARES system, transmitting the same information to the Medicaid fiscal intermediary.

c. The Partnership intake staff will send the Title XIX Level of Care forms and the signed enrollment request to the Medicaid fiscal intermediary. The Medicaid fiscal intermediary will enroll the member, and issue a new Medicaid card indicating enrollment in the Partnership Program. The Medicaid fiscal intermediary will issue capitation payments to the Partnership organization effective as of the date the Enrollment Request was signed.

d. If the member is Medicare eligible, the Partnership intake staff will send a copy of the signed enrollment request to the Medicare enrollment agency. The Partnership intake staff will also transmit enrollment electronic information to the Medicare enrollment agency to enroll the member in the Partnership organization.

The Medicare enrollment agency will instruct the appropriate Medicare fiscal intermediary to issue capitation payments to the Partnership organization effective the first date of the month following the date the Enrollment Request was signed, as long as the processing date is five (5) or more days prior to the end of the month. If the processing date is less than five (5) days before the end of the month, the Medicare enrollment agency will instruct the appropriate Medicare fiscal intermediary to issue capitation payments to the Partnership organization effective the first date of the second month following the date the Enrollment Request was signed.

e. The Partnership organization will retain file copies of all enrollment documents in the member record.

f. Whenever the enrollment of a member exceeds sixty (60) days, the Partnership organization shall prepare an Enrollment Plan for that individual. An Enrollment Plan details the actions that are needed to facilitate and accelerate the enrollment of the prospective member. (Enrollment Plans shall be available for Department's review upon request.)

Reference:
Medicaid CFR 434.25
Medicaid CFR 435.217
Medicaid CFR 456.350-456.380
Medicare CFR 417.430
Dual Waiver Contract, Article VIII

Cross Reference:
Marketing
Informed Choice
Lock-In
Member Handbook
Open Enrollment
Eligibility Criteria
Financial Eligibility
Intake
Functional Eligibility
Provider Network

Partnership Medicaid/Medicare Enrollment Request Form

<<Insert Partnership organization's name, address and phone number>>

Complete the Following: (please print)

1. First Name:	MI:	Last Name:	
2. Phone Number:		Social Security Number:	
3. Street Address:		City:	Zip:
4. Date of Birth:	County of Residence:		
5. Medicaid Number:			
6. Medicare Number:	Effective Date of Part A:	Effective Date of Part B:	
7. I am currently receiving hospice benefits in a Medicare certified hospice? 9 Yes 9 No			
8. I have end stage renal disease (ESRD) 9 Yes 9 No			

Under this health plan, I understand:

That (**Partnership organization**) will be providing my care covered by both Medicare and Medicaid. If I am enrolled in another HMO which offers a Medicare plan, by enrolling in (**Partnership organization**) my membership in my current HMO will be canceled.

(**Partnership organization**) must arrange for or provide all medical care covered by Medicare and Medicaid. I have received information on how to obtain emergency services and urgent care and I understand that I am not financially responsible for any emergency or out of area urgent care.

By enrollment in (Partnership organization), I authorize:

The disclosure and exchange of information between the PACE/Partnership organization and State and Federal oversight agencies or their authorized representatives.

9. Signature:	Date:
10. Relationship to the member (if applicable):	Phone:

*****For WPP Use Only*****

Date of Enrollment:_____

9 PACE

9 Partnership

*****For Fiscal Agent Use Only*****

Date of Enrollment:_____

Instructions

for filling out the Wisconsin Partnership Program Enrollment Form

T Please print as neatly as possible.

T If you ask, we will give this information in another form, such as Braille, large print or audio tape.

T If you need the assistance of an interpreter, please contact (Partnership organization name and phone number).

Please fill in the following information by numbered line on your enrollment form:

1.	**Name:**	Write in your name (first name, middle initial, and last name).
2.	**Phone Number:**	Write in the phone number where you can be reached.
	Social Security Number:	Write in your Social Security Number (not your Medicare number). You can find this number on your Social Security card.
3.	**Street Address, City and Zip:**	Write in where you are currently living.
4.	**Date of Birth:**	Write in the day you were born including the year.
	County of Residence:	Write in the county where you live.
5.	**Medicaid Number:**	Write in your Medicaid number.
6.	**Medicare Number:**	Write in your Medicare number (not your Social Security number). You can find this number on your Medicare card that says AHealth Insurance Social Security Act≅ at the top.
	Effective Date of Part A:	On your Medicare card it will say Hospital Insurance with a date after it. Write that date on this line.
	Effective Date of Part B:	On your Medicare card it will say Medical Insurance with a date after it. Write that date on this line.
9.	**Signature:**	You must sign and date the bottom of the form.
10. If you sign on behalf of the member:		Write in your relationship to the member and your phone number.

Partnership Enrollment Agreement

<<Insert Partnership organization's name, address and phone number>>

I have received a member handbook from (Partnership organization), which includes a description of benefits available, including all Medicare and Medicaid covered services, and how services can be obtained.

I have received a list of current providers. I understand that I may request additional providers for the network including a primary care physician at enrollment time.

I understand that my Partnership team and physician will authorize services. If I wish to obtain services outside the Partnership Program network, I must obtain prior approval from the Partnership organization, or I will be financially responsible.

I have received information on grievance and appeals procedures and the member's rights and responsibilities.

I have been asked whether I have advance directives or if I would like to discuss advance directives further with (Partnership organization) team.

I have received information on how to obtain emergency services and urgent care and I understand that I am not financially responsible for any emergency or out of area urgent care.

I understand that I may voluntarily disenroll from (Partnership organization) at any time. I understand that my disenrollment will be effective within two (2) months of signing the Disenrollment Request Form.

I understand that I may be contacted for ongoing quality assurance by (Partnership organization) personnel or someone outside of the program authorized to do quality assurance. I understand that my participation is voluntary.

I authorize the disclosure and exchange of information between the (Partnership organization) and State and Federal oversight agencies and their authorized representatives.

Signature:_____ Date:_____

Printed Name:_____

Enrollment and Disenrollment Systems

Non-Enrollment

Policy Statement:
All people who are financial and functionally eligible, and interested in enrolling, will be enrolled in the Wisconsin Partnership Program. Non-enrollment for eligible potential members may occur under the following conditions with approval from the Department of Health and Family Services.

Non-Enrollment may occur when:

1. The individual has a demonstrated history of physical aggression which places others and/or self at risk as demonstrated by clinical/medical records, family information, etc.,

   AND, documented previous attempts at treatment or plan intervention have been unsuccessful, resulting in physical risk to the individual or others.

2. The potential member has a history of willful non-compliance with an essential treatment plan which has resulted in significant physical risk to the individual as demonstrated by clinical/medical records

   AND, that risk continues.

3. The potential member and/or potential member's family/guardian express desire that the potential member remain in own home (i.e., home of family or personal residence)

   AND the potential member lacks appropriate natural supports necessary to be sustained at home with an acceptable level of risk

   AND lacks cognitive ability to understand the risk.

4. The potential member and/or potential member's family/guardian express desire that the potential member remain in own home

   AND the potential member is medically frail, requires substantial hands-on overnight care either permanently or on long term basis, and lacks the natural supports to be able to develop a care plan for the in-home overnight care.

5. The potential member has a less-than-six-month life expectancy.

6. The potential member and/or potential member's family/guardian refuse an essential component of the treatment plan.

7. The potential member, at the time of referral, is living in substitute care (substitute care includes but is not limited to Nursing Home, Adult Family Home, or CBRF) with no desire to change residence or cannot with natural supports and the program return to their own or their family home.

8. The potential member has a primary diagnosis which is excluded in the capitation rate.

9. The potential member's physician does not meet Partnership criteria or the potential member's physician refuses to participate in the Partnership model and the potential member refuses to change physicians.

Procedure:

1. Request for Non-Enrollment
   Within 5 days of the contractor's decision to request non-enrollment, the contractor must send the following information to the Department:

   a. Statement requesting denial

   b. Contact information including the person's name, address and phone

   c. The reason for denial and supporting documentation

2. Department Review Action
   a. The Department will review the request for non-enrollment and either approve or disapprove it in writing within 15 days

   b. If the Department disapproves the request for non-enrollment, the contractor will contact the person and offer enrollment

3. Notification
   If the Department upholds the denial of enrollment, the Partnership organization must notify the person denied membership of the following information in writing:

   a. A statement that the enrollment will be denied

   b. The specific protocol and supporting documentation

   c. A statement about the member's right to challenge the non-enrollment decision

   d. Notification that the person may grieve in writing to the Department

Cross Reference:

Grievance and Appeals

Enrollment and Disenrollment Systems

Disenrollment

Policy Statement:
Members have the right to request disenrollment from the Wisconsin Partnership Program at any time. Partnership organizations may also disenroll members involuntarily with the approval of the Department of Health and Family Services (DHFS).

I. Voluntary Disenrollment

Members may request disenrollment at any time. The contractor will work to assure the disenrollment process occurs as promptly and smoothly as possible. The Partnership organization staff will facilitate the member's transition to Medicaid and/or Medicare, and other community services to which the member may be entitled.

Procedure:

1. When a member notifies any Partnership organization staff person of his or her intent to disenroll, he or she will be asked within 5 business days to sign and date a **Disenrollment Request Form**.

2. The Partnership organization's staff person will also sign and date the disenrollment request form, acknowledging the request for disenrollment, and return a copy to the member.

3. On receipt of a signed Disenrollment Request Form, the Partnership organization must within three (3) business days forward copies to the Medicaid fiscal intermediary and the Medicare enrollment agency (via DHFS).

4. If the Medicaid/Medicare fiscal intermediaries receive the member's request to disenroll by the ninth day of the month, the **Disenrollment Date** will be the last day of that month. If Medicaid/Medicare fiscal intermediaries receive the member's request to disenroll after the ninth of the month, the **Disenrollment Date** will be the last day of the following month.

II. Involuntary Disenrollment

An involuntary disenrollment may occur when:

1. The individual has demonstrated history of physical aggression which places others and/or self at risk as demonstrated by clinical/medical records, family information, etc., AND, documented previous attempts at treatment or plan intervention have been unsuccessful, resulting in physical risk to the individual or others.

2. The member has a demonstrated history of ongoing, willful non-compliance with an essential treatment plan which has resulted in significant physical risk to the individual as demonstrated by clinical records AND that risk continues.

3. The cognitively impaired member's informal support system fails to protect the member from abuse and or neglect in the home setting AND there is significant risk to the person, AND the family or guardian refuses an alternate living setting.

4. The program no longer has a contract with the member's physician, and the member refuses to change physicians.

5. The member no longer meets eligibility criteria.

Procedure to Request Involuntary Disenrollment

1. The Partnership organization must submit a request for involuntary disenrollment to the Department of Health and Family Services. Evidence must be attached supporting the request.

2. The Department of Health and Family Services will approve or disapprove the disenrollment request and notify the Wisconsin Partnership organization of the decision.

3. If the disenrollment request is approved by the Department, the Partnership organization must notify the person in writing of the following:

    a. A statement that the Partnership organization intends to disenroll.

    b. The reason(s) for the intended disenrollment.

    c. The specific protocol that supports or requires the action.

    d. A statement about the member's right to challenge the Partnership organization's decision, an explanation of the grievance and appeals process, and time frame for filing a written grievance. In order to continue enrollment, the member must file a written grievance with the Partnership organization or the Department of Health and Family Services within ten (10) days of the decision to reduce or deny the service.

4. If the DHFS approves the Partnership organization's request to disenroll the member, the Partnership organization must, within three (3) business days, forward copies of the Disenrollment Form to the to the Medicaid fiscal intermediary and the Medicare enrollment agency.

    If the Medicaid/Medicare fiscal intermediaries receive the member's request to disenroll by the ninth day of the month, the **Disenrollment Date** will be the last day of that month. If

Medicaid/Medicare fiscal intermediaries receive the member's request to disenroll after the ninth of the month, the **Disenrollment Date** will be the last day of the following month.

5. If the member files a written grievance of the disenrollment within the appropriate time frame, disenrollment is delayed until the grievance is resolved.

6. If the disenrollment request is disapproved by the Department or in the resolution of a Grievance process, the Partnership organization will continue to serve the member.

III. Disenrollment Process

The Partnership organization will facilitate disenrollment, whether voluntary or involuntary, and it will be processed in the following manner.

1. The Wisconsin Partnership Program will continue to provide all needed services until the Disenrollment Date, upon which capitation payment ends.

2. The Partnership organization will notify the Medicaid fiscal intermediary to disenroll the member from the Wisconsin Partnership Program, terminate the capitation payments, and issue a new Medicaid card (if the client continues to be Medicaid eligible) effective on the Disenrollment Date.

3. The DHFS will notify the Medicare enrollment agency to disenroll the member from the Wisconsin Partnership Program, terminate the capitation payments, and issue a new Medicare card (if the client continues to be Medicare eligible) effective on the Disenrollment Date.

4. The Partnership organization will notify the member of their disenrollment date.

5. The Wisconsin Partnership Program Manager and Team members will notify the member's primary care physician, and coordinate the member's transition to Medicaid or Medicare services, and other community services to which the member may be entitled.

6. If the Partnership demonstration phases out, the Department with or without the assistance of the Partnership organization will prepare a phase-out plan and submit it to HCFA, at least six months prior to initiating normal phase-out activities.

IV. Death Procedure

1. In the event of a member's death, the Partnership organization will report the death to the Medicaid Fiscal Intermediary and the Medicare Enrollment Agency, using the appropriate disenrollment forms. Medicaid disenrollment will be effective immediately (capitation ends as of the date of death). Medicare disenrollment is the same as III., above.

Reference:
Medicaid CFR 434.27
Medicare CFR 417.461